

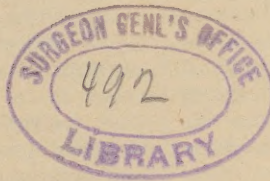
MANLEY (T.H.)

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BY

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NEW YORK CITY.



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Something More on the Pathology and Treatment of Hemorrhoids, Fissures, Fistulas, and Ulcers in the Ano-Rectal Region, With a Few Notes on Prolapsus Ani and Neoplasm.

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In the issue of the MEDICAL BRIEF for April, 1892, a contribution was offered by me on the subject of hemorrhoids, internal and external; internal bleeding and external ulcerating; fissures, ulcers, etc., and their treatment; safe, rapid and radical; by cocaine-analgesia—pressure—massage—thorough anal dilatation and local applications, thus sparing the patient the dangers always attendant on an excessive loss of blood, when mutilating measures are resorted to; and those immediate, or ultimate, which follow the profound coma of pulmonary anesthesia. The kindly spirit with which my humble efforts in that essay have been acknowledged by many readers of the BRIEF have stimulated me to continue the discussion of the subject then opened; and I now add to it a few words on fistula-in-ano and anal-hernia, or, as it is commonly designated, prolapsus-ani and anal-neoplasms.

HEMORRHOIDAL DISEASE, ETC.

The pathological condition so common in all civilized communities which causes piles, is one of the penalties which man has to pay for his civilization. Heavy eating, deficient or excessive exercise, irregularity in defecation, with excessive indulgence in venery, each and all play its important role as *primitive* causes.

Anything which leads to a stasis in the portal or general venous circulation makes its impress felt in the large dependent vessels of the lower rectum.

Certainly, we must not lose sight of the occasional association of constitutional dyscrasia, as tuberculosis, syphilis or cancer, in all those disorders attended with a disordered local nutrition in the recto-ischiatic fossa.

In the vast majority of cases, hemorrhoids are primarily responsible for fissures, ulcers, hemorrhages, strictures, and

fistulas in the ano-rectal region. It would appear that if this premise were indisputable, that as soon as we are assured that one has hemorrhoids, as a prophylactic measure, we should advise their immediate ablation. It will be remembered, that in my original pamphlet, I stated that it was only exceptionally that piles gave any annoyance, except in the presence of inflammatory or degenerative changes. And that it was a pathological condition which few were entirely free from. Besides, the operation which we might perform, in cutting away the hemorrhoids, might pave the way for the very condition which our efforts were supposed to prevent, for, it is not uncommon, that the most troublesome fissures and fistulæ often follow cutting operations on piles.

The pathological ground-work of common, uncomplicated hemorrhoids, it is assumed, is well understood. Now, we will briefly consider those cases which may not only render one's existence very miserable, but even destroy life itself.

When those large varicosities are within the sphincter, through pressure of fecal scyballæ, or through violent straining, inflammation first attacks the mucous envelope of the hemorrhoidal masses, and in consequence our patient will pass, when a tenesmic strain comes on, a thick, ropy mass of rusty colored mucus. This inflammation in many goes on spreading until it invades the sub-mucosa and the intermuscular cellular tissue of the external sphincter-ani. Now, the trouble commences. Chronic hemorrhoids, hemorrhoidal ulcers or fissures, are attended with three characteristic symptoms, which may occur simultaneously, consecutively, or single.

They are *pain, hemorrhage* or *itch*.

It must not be inferred that these clinical phenomena are invariably and solely associated with the conditions named; or that they may not also, in occasional cases, indicate pathological processes, which possess no affinity to piles at all. Nevertheless, they are such constant phenomena in hemorrhoidal disease, as to be regarded as nearly pathognomonic.

In order to correctly appreciate abnormal, organic changes in the recto-anal region, and interpret their significance, it is well that one first familiarize him-

self with its normal, living anatomy, so to speak.

We derive but little information from an ocular inspection, unless, the anal mucous membrane is everted, or we have the sphincter dilated. So that, unless some small, atrophied tabs remain, or there are some scattered hemorrhoidal tumors, little further information is derived by the eye. If we find the clothing over the nates soiled, and the coverings of the ischiatic fossa moistened, we may suspect incontinence of the feces, fissure, or fistula.

As a diagnostic aid there is nothing here like the experienced tactile touch. Passing the warm, lubricated pulp of the index finger up against the normal sphincter, it has a soft, resilient feel, and its smooth, velvety border, painlessly yields to the introduction of two or three fingers, when the muscle is coaxed, as it were, by very gentle, steady pressure. As the fingers enter, and press gently in every direction, it will be surprising to the uninitiated how freely mobile and enormously capacious is this musculo-membranous terminus of the alimentary canal. As the internal sphincter, so called (or rather an aggregation of involuntary muscle fibres in the wall of the intestine), is reached, we encounter another constriction, but with neither of the quality or power of the external. Now, as we press backward, we invade the large ischio-rectal fossa, and the hollow of the sacrum. Pushing forward, we directly impinge on the prostate and bladder. As we partly withdraw the finger and sweep its tip around the junction of the sphincter with the rectum, we will note that the surface is smooth, elastic and regular in every direction. Having made an intelligent digital examination internally, and completely removed the fingers, an eversion may follow; the sphincter, now tired, fails to contract immediately, and we behold a condition, misnamed by some writers, "paralysis of the sphincter."

If now, we can, by specula or other means, examine the glandular surface of the ano-rectal segment, we will observe that in health, in early life, the rectum is generally empty as far as the sigmoid-flexure, with its collapsed walls lying in immediate contact with each other.

As might be supposed from our physiological knowledge of the rectum, its lower sub-mucous tissues are highly vascular. Here we will discover that its arterial supply is from two independent sources, and its venous channels belong to the portal and general systemic circulations.

So much for the normal state. As must be obvious to us, when we remember the immense diversity of pathological conditions which obtain here, every sort of transition in the anatomical elements is observable in the presence of various abnormal conditions.

A patient will tell us that he has distress in defecation; has pain. The feces come away in a thin, convoluted spiral form, and are blood-tinged on the surface. In nine cases out of ten, the first thought will be, *piles*; and, as a matter of routine either some soothing salve or enema is prescribed. But, he, who would prescribe on scientific lines, will give neither medicine nor opinion until he has had physical evidence of what the pathological state actually is.

He introduces his finger, or tries to, when he discovers a tight cicatricial contraction at the portal of entry, from the healing of anterior syphilitic or tubercular ulcers. There has been a loss of substance. Again, the medical attendant may pass the finger through the sphincter, and he finds the entire lumen of the intestine stuffed with a new growth of a benign or malignant nature. He may, too, find the rectal walls crowded together from the pressure of a neoplastic formation wholly outside of the walls of the intestine. I say, then, when we prescribe for piles, let us be sure that we are correct in our diagnosis.

Every case of rectal disease, before any sort of treatment is recommended, should be thoroughly examined by the touch, dilatation and inspection. Many times a patient will complain of a persistent, intolerable itching; a veritable pruritus ani, in vain applying over the sphincter any sort of ointment and lotion, without any relief. When this occurs in a male, near or past the meridian of life, "*open the door and look in*," and the phantom will have materialized, so that you may easily master him. A gentleman came to me in great distress with this affliction, who had been tortured for years. Dilating

the sphincter well, there, at the posterior aspect and about five lines from the external sphincter, was a deep, "punched-out" ulcer. I carried the edge of the scalpel from the bottom of this hiatus through the sphincter, cut away its caloused edges and scraped its base. Healing was prompt, and that ended the itching.

Another similar case was sent to me which had proved rebellious to treatment. This man was decidedly tuberculous. Here, I noticed that the parts were moist. On bringing his buttocks into good light, I found a pin-hole fistula, which permitted a probe to pass away up beyond the internal sphincter. I advised against any cutting, but I thoroughly stretched the sphincter and washed out the fistula with a weak corrosive solution. He has had no itching since, though as the pathological condition, which gave rise to the trouble, remains, no doubt this must be repeated.

Much might be written on so-called fistulas-in-ano (?). I say so-called, because a large proportion of them have no connection with the anus at all. For this latter class, "*ischio-rectal fistula*" would be most appropriate. With these the external opening is always external to the elliptical fibres of the sphincter muscle; and, when they have an internal aperture, it is any distance; from one-half to four or five inches, or more, above the sphincter. I have seen one of these puzzling fistulous diseases which had its origin in a prostatic abscess. A psoas abscess has been known to make its way under the pelvic fascia, burrowing down by the bowel, in the direction of gravity, to drain through an opening near the anus.

The cause of rectal or anal fistula has been a controversial subject for ages. To cite the views of the various authors who have written on this, would be an interesting but profitless task, for they are so antagonistic in many particulars that one, after reading them, would be "between the devil and the deep sea," in trying to reconcile their conflicting notions. With few exceptions, however, they all agreed that there was some remote connection, clinically, between anal-fistula and pulmonary-phthisis, and when this was clear and decisive, they declined to operate.

My own conclusion now, after several years of experience with this class of cases, is that the old authors were right. I say this because I am acquainted with several cases in which the wound, after division of the tissues, has failed to heal; or if it did the fistula relapsed. Besides, I have met with *fistula-in-perineo*, too often associated with tuberculosis, to regard it as a mere coincidence. Hence, in my humble opinion, unless the fistula is a cause of considerable local distress it should *never* be cut. And even with this class, since I have instituted "orificial-dilatation" with cocaine-analgesia, I have generally succeeded in removing, permanently, all painful symptoms without the loss of blood. It is not material whether the fistula is internal or external, complete or incomplete, with vigorous antiseptic drenching of the fistulous tract and repeated dilatation, unless the tubercular cachexia is well advanced, they are usually promptly cured.

Rectal ulcers in varying degrees are probably a common affection; when simple and uncomplicated, undergoing spontaneous cure. They no doubt have their origin in hemorrhoids and in the solitary glands of the rectum; probably, in many cases, breaking down by a process of suppuration in the beginning, and opening into the rectum.

Their most prominent symptoms are itching and hemorrhage. Their unfortunate sequela, independent of infection and loss of strength, is cicatricial contraction, stricture of the bowel. If treated early this may be prevented or greatly limited. In this variety of fibrous *non-malignant* stricture, rectal sounds may be employed in dilatation with advantage, but in the cicatricial contraction, which follows *malignant* or *cancerous* ulceration, the introduction of any sort of a dilating agent should be vigorously condemned, and under *no* circumstances, whatever, be permitted. I was, not long ago, invited to Brooklyn to see a case of anal disease, in which the patient had great distress in evacuating his bowel. The practitioner was using a number of bulky bougies for dilatation. On examining our man, I found his rectum one enormous mass of a horny infiltrate. I pronounced the case malignant, and advised against dilatation, saying, that the

proper and only relief was in excision of the rectum or a colotomy. My medical friend did not agree with me, but the unfortunate man was dead, from obstruction, before the week was out.

I was called, in haste, to a woman last spring. They told me she had obstruction of the bowel, and was dying. When I arrived, I saw a set of rectal bougies on the table, which had been employed on her. I took my cue from this that her trouble was rectal in origin; and, in passing my finger into her rectum, I found a malignant mass, which packed the gut as completely as so much moulten lead. Nothing, absolutely nothing, could get through. Her abdomen was enormously distended with imprisoned feces, which she was now throwing up by way of the stomach. As she was slowly sinking from the absorption of her own excrement; and there was no prospect of recovery in her collapsed state, I declined operation.

So far I have not discussed, *in extenso*, fistula, rectal ulcerations, or stenosis, except, as they occur as sequelæ of hemorrhoidal disease, though, I hope, at some future date, to deal with these important diseases from the standpoint of their elementary pathology, and their full treatment, local and constitutional, tentative and radical.

In concluding this part of my subject, I would say, that the same precise methods must be observed in the treatment of the consecutive lesions of hemorrhoids, as previously laid down for the primary malady itself, in a former issue of this journal, *i. e.*, aseptic and antiseptic details must be applied with energy. Cocainization must be complete and thorough; using the fresh drug and spraying subcutaneously the diseased areas and the radiating fibres of the sphincter muscle, *before* distention is commenced.

RECTAL-HERNIA OR PROLAPSUS-ANI. ANAL-TUMOR.

I herewith reproduce two cuts, which have been under my care and have previously been considered in detail in the *Medical Age* (September 10th, 1892).

I prefer the designation rectal-hernia to prolapse of the anus; because the latter term but very imperfectly defines the condition, for when the extrusion is

of any size, it consists rather of rectal, than anal, tissue. I give it the designation *hernia*, because all the etiological elements in its production are present, which we meet with in the above disease: As, a weakening, want of tone, and giving way of a ring—the anus—an excess of intestine, elongation of the mesentery; with a strain in its final evolution.

The treatment of this infirmity is hernial, too. We treat prolapsus, or procidentia, by taxis, or truss-support. In an inguinal hernia, the sac of which contains omentum, we very readily and radically cure by excision. So, in chronic old cases of prolapse, when tentative measures fail, we can radically cure it by its complete excision; an external enterectomy.

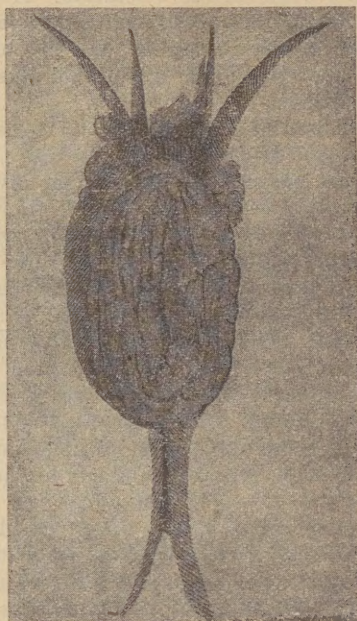


Figure 1.

1st Case. This was a highly interesting case, because of the long time which the woman suffered, and because, too, all former tentative measures failed; even the firing of the anal mucous membrane with the galvano-cautery. She was a confirmed invalid when she was sent to me by Dr. James Reilly, of this city. She was forty-six years old, a widow. It was four years before I saw her that her rectum was cauterized. I operated on her by resecting the entire extrusion,

four years ago, and there has been no relapse since.

The second case was remarkable, inasmuch, as though on coming under my observation, the mass extruded was of enormous proportions, and had existed for a long time, yet, by rest, internal medication and good hygiene, he was entirely cured by us, without any sort of



Figure 2.

an operation involving the loss of a drop of blood.

He was a German, thirty-two years old, who, for more than a year, was obliged to discontinue work of every description, as with every effort at defecation, the entire rectum would roll out, and when replaced, would immediately descend again.

Its mucous covering was chafed, fissured and bleeding when I first saw him, and was nearly the size of an infant's head.

The above photograph was taken when the process of cure was nearly complete.

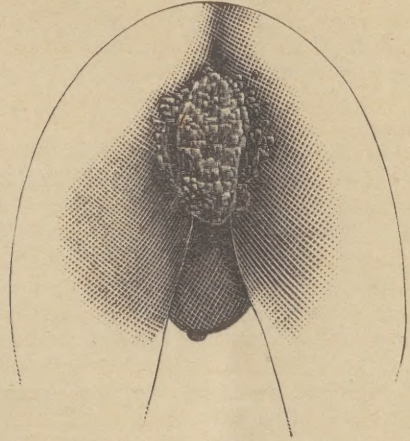


Figure 3.

The subject of this cut was a young Italian of middle size and fair general health.

The mass had been coming for more than a year, advancing by slow stages at first, but rapidly increasing in volume as time advanced. The disease had been diagnosed epithelioma. But, as it did not present the gross microscopical features, nor clinical history of a malignant neoplasm, this was excluded. Its cauliflower contour and surface were clearly demonstrated, and, from our examination it was evidently of venereal origin. The mass was completely cleared away from the external aspect of the sphincter, and he was placed on specific treatment. He made a rapid and uneventful recovery.

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